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Perihepatitis in women with salpingitis—an under-diagnosed clinical entity?

Perihepatitis, also referred to as Fitz-Hugh-Curtis syndrome (FHCS) is reported to occur in 5 to 15% of women with salpingitis, based on laparoscopic findings.¹ Although *Neisseria gonorrhoeae* was described as the causative organism in the cases reported earlier, *Chlamydia trachomatis* is now recognised as responsible for most cases of perihepatitis.¹ Three patients with FHCS were recognised and treated during a twelve month period in a department of genitourinary medicine.

The first patient was a 27 year old waitress, who was admitted as an emergency to the surgical ward as a suspected case of cholecystitis. She complained of having developed a colicky lower abdominal pain 14 days prior to admission, which, after ten days, migrated to the right upper quadrant. Pain was pleuritic in nature and radiated to the back. She was pyrexial, tender in the right iliac fossa and right hypochondrium and required parenteral analgesics for the relief of pain. Perihepatitis was suspected and she was referred to the genitourinary medicine clinic for confirmation. *C. trachomatis* from the cervix was detected. Serological tests for anti-chlamydial antibodies showed the presence of IgM and the microimmunofluorescence (micro-IF) test showed the IgG titre to be >4096. Perihepatitis was subsequently confirmed at laparoscopy and she responded to a two week course of doxycycline combined with a week's course of metronidazole.

The other two patients presented with similar symptoms but with lesser severity. *C. trachomatis* was detected in both instances and their serological tests showed anti-chlamydia IgG titres to be >1024. Both patients responded to therapy with doxycycline. Partner notification was successfully completed in all three instances.

Patients with FHCS can present to a variety of disciplines,^{2,3} and the incidence is probably an under estimate. Diagnosis should be suspected in women who are young and who present with right upper quadrant localisation of pain which is pleuritic in nature, associated with uterine and adnexal tenderness on pelvic examination. Detection of *C. trachomatis* from the lower genital tract together with the demonstration of high titres of anti-chlamydial IgG (>1:1024) and the presence of IgM antibodies should strongly suggest FHCS.¹

Although laparoscopic detection of violin string adhesions between the liver capsule and the anterior abdominal wall is essential for confirmation, a recent report has suggested that ultrasound can be used to confirm the

diagnosis.⁴ If proven, the latter may eventually replace invasive laparoscopic procedures for confirmation of the diagnosis. The role of the genitourinary physician is vital not only to exclude other sexually transmitted diseases and ensure appropriate therapy, but also to treat contacts so that the risk of reinfection is eliminated.

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Importation into the UK of a strain of *Neisseria gonorrhoeae* resistant to penicillin, ciprofloxacin and tetracycline

We report here what we believe to be the first isolation of a strain of penicillinase-producing *Neisseria gonorrhoeae* with high-level resistance to ciprofloxacin and tetracycline.

On the 3 February 1995 a 35 year old divorced male travelled to Angeles City in the Philippines on business. Here he had sexual contact with a local prostitute. He subsequently travelled to Australia by which time he had developed a bloody urethral discharge. He was prescribed 500 mg of tetracycline with 500 000 units of nystatin ("Mysteclin") orally twice daily for 14 days. On return to the Philippines his urethral discharge was still present and he was prescribed 300 mg rosoxacin (a 4-quinolone) *stat* orally. The patient returned to the UK at the end of February with the urethral discharge still present. The patient had had no UK sexual contacts since January. He was examined at his local genitourinary medicine clinic where intracellular Gram-negative diplococci were seen in a smear of the discharge. Urethral swabs were taken for culture and chlamydia antigen assay. He was prescribed 500 mg of ciprofloxacin *stat* and a 10 day course of ofloxacin (400 mg daily) was started.

The urethral swab taken at this time yielded oxidase-positive Gram-negative diplococci after 48 h incubation on New York City medium at 37°C in 5% CO₂. This organism was identified as *N. gonorrhoeae* by the carbohydrate utilisation and Phadebact Monoclonal GC tests. The strain was demonstrated to be β -lactamase positive and found by agar dilution antibiotic sensitivity testing to be resistant to penicillin (minimum inhibitory concentration (MIC) >10 mg/l), ciprofloxacin (MIC 16 mg/l) and tetracycline (MIC 64 mg/l) but sensitive to spectinomycin (MIC 32